

MEMORANDUM

October 8, 1997

TO: Richard Turman
FR: Sarah Bianchi
RE: Statistics on Race and Health

Melanie Nakagiri informed me that you were interested in some background information on existing racial disparities in health status. Attached are some statistics we have pulled together. Chris and I are also planning to forward you a memo shortly on some possible initiatives in these areas you may want to consider. The President has indicated that he is interested in considering ways to eliminate some of these health disparities as part of his overall race initiative this year. Chris has already mentioned to Josh that we would like to discuss with you what ways might make sense to address these issues in the upcoming budget. HHS has also indicated their interest to discussing whether it makes sense to modify their FY1999 discretionary budget to reflect the President's interest in addressing some of the existing disparities. We are setting up a meeting with HHS either on Friday or early next week. I will let you know when that meeting is set up. Perhaps it would make sense for us to talk before then.

The Department has identified six areas with significant racial disparities including: infant mortality, breast and cervical cancer, cardiovascular disease and strokes, diabetes, HIV/AIDS, immunization rates. The Department's general criteria, as best we understand it, is to identify areas where there are health disparities in more than one race/ethnicity group. We believe that the Department's list captures most of the major health areas with racial disparities.

One exception to that, however, is cancer. There are racial disparities in a number of different kinds of cancers -- not just breast and cervical. Breast and cervical cancer are the cancers that may have the most disparities across a number of race/ethnic groups (I am not sure). There has been a great deal of interest in cancer-related issues expressed to us both by the Vice President and the First Lady (an issue we would like to discuss with you separately), which we believe would justify considering initiatives for cancers other than breast and cervical, even if the disparity only exists for one race/ethnicity group. There are also some major disparities for asthma which we believe may be worthwhile to consider.

MEMORANDUM

October 3, 1997

TO: Bill Corr
FR: Chris Jennings and Sarah Bianchi
cc: Elena Kagan

Attached are few suggestions you may want to consider for possible new increases and initiatives in the areas the Secretary has identified as having significant racial disparities. We would like to set up a meeting this week with you and OMB to discuss these ideas in addition to the options that you have been considering.

CARDIOVASCULAR DISEASE AND STROKES. The HHS initiatives to begin to address the race-oriented disparities in cardiovascular diseases are clearly worth doing. We believe that we should consider building on your recommendations by initiating a national prevention effort to educate both the public and health providers as to how best reduce the incidence of this disease. It may be useful to consider a multifaceted initiative to increase awareness about prevention, particularly among Native Americans, African-Americans, and Hispanics. Based on preliminary discussions with the American Heart Association and others, an initiative such as the one outlined below could make a substantial impact:

- **A Nationwide Education Campaign.** This campaign -- which could have an special emphasis to target minority communities -- would educate health providers and high risk populations about how to prevent cardiovascular disease and stroke. It would stress the importance of keeping blood pressure under control, the need for physical activity, and reducing tobacco use. It could include PSAs and other national-based efforts (such as the President or the Secretary launching healthy heart walks in major cities) as well community-based efforts based on successful outreach models (such as "Search Your Heart"-- a church-based heart health program for African-Americans run by the American Heart Association);
- **Coordinated Cardiovascular Efforts in Every State.** Another aspect of this initiative could include funding for state or local health departments to begin a cardiovascular outreach program, just as many of them have efforts to reduce infant mortality, AIDS, and other major health problems. With this new stable source of funding, state and local health departments could bring together community-based organizations and coordinate state and local prevention activities;

- **Special Grants for Enhanced Prevention Efforts in Certain High Risk Communities.** These grants, similar to Healthy Start Grants for infants, would fund enhanced efforts in a select number of communities with a particularly high incidence of heart disease. In these selected areas HHS would partner with community-based efforts and local institutions to develop a multi-faceted approach to reduce cardiovascular disease and stroke.

CANCER

Breast and Cervical Cancer Prevention. We agree with your strategies for reducing the incidence and mortality for breast and cervical cancer, including increasing public education campaigns to address the benefits of mammography and improving access to optimal care for minority women. As you note, the CDC breast and cervical screening program currently helps address these goals by providing screening to low-income women, and over 40 percent of the women currently screened by this program are minorities. We would be interested in considering expanding this program to screen thousands more low-income minority women. This expansion could also include new education efforts about prevention and the importance of mammography and cervical screening.

Other Cancer Initiatives. We recognize the Secretary's rationale for the identified health areas this initiative should target. However, we believe it is worth pursuing some other cancer initiatives that have the potential to reduce racial disparities. Within the White House, there is increasing interest in cancer-focused interventions, which may provide rationale for expanding our efforts in this area.

I. **New National Effort to Reduce Deaths from Colorectal Cancer**

Problem: Colorectal cancer is the third most commonly diagnosed cancer for both men and women and the second leading cause of cancer deaths. African-Americans are more likely to be diagnosed with it and more likely to die from it and mortality trends indicate that the gaps between blacks and whites are widening. Experts from NIH, CDC, and the American Cancer Society have come to a unified conclusion that screening for colorectal cancer does reduce mortality. These conclusions have led to new screening recommendations, which at this time are not widely known by health providers or the public at large. There is also not currently a screening initiative for this type of cancer for low-income Americans as there is for breast and cervical cancer.

New Colorectal Education and Screening Initiative. We believe that a major outreach effort, similar to the one the Department has led to encourage mammography screening, would be extremely beneficial. A major screening program for low-income and high-risk populations -- similar to the one for breast and cervical cancer at the CDC -- combined with a national campaign to educate the public and health care providers about the importance of screening would encourage more Americans to get screened for this cancer. This initiative would not only be an important component of the race and health initiative but would also be a new screening program which demonstrate that HHS is

keeping cancer prevention efforts in line with the most up-to-date medical research.

II. Improving minority participation in clinical trials

Problem: There are large disparities in the number of minorities participating in many cancer clinical trials, particularly prevention and screening trials. Minorities are less likely to be aware of the benefits of such trials or to have access to them. For some cancers, such as prostate cancer, there is also a problem of participation in treatment trials. For example, prostate cancer mortality and incidence rates are much higher among African-Americans than whites.

National Efforts to Encourage Minorities to Participate in Clinical Trials. Some possible options to increase the participation among minorities in clinical trials might include working through the Clinical Trial Education Initiative at the National Institutes of Health or through the Louis Sullivan Black Leadership Initiative on Cancer or through other education efforts to increase participation in these trials. We also interested in discussing special initiatives, through the NIH or elsewhere to encourage African-American men to participate in clinical trials for prostate cancer research.

III. Biomedical Research for Minorities

Problem: While we are aware that NIH and others do carefully consider the appropriate level of minority-related research, there is longstanding concerns in the minority community about the level of emphasis of biomedical research on minority-related concerns.

National Conference on the Status of Biomedical Research for Minorities. We are interested in your thoughts on whether it would be appropriate to call for a meeting or conference on the status of biomedical research for minorities or on ways to better involve minorities in existing biomedical research. While we well understand that scientists should make decisions about what kind of clinical trials or other biomedical research gets funded, if there are new projects or research initiatives that NIH is launching, we believe it might be useful to consider ways to highlight them.

DIABETES. We are pleased that the Department's FY 1999 budget request includes a \$16 million increase for diabetes programs at the CDC. We are interested in how this new funding can best be used to reduce the burden of diabetes among minorities, what initiatives you are considering for this new funding, and how best to highlight them. We understand that twenty percent of CDC's new funding would go to the National Diabetes Education Program which would have an emphasis on targeting minority communities. We believe that this new HHS increase, in addition to the \$30 million per year for Native Americans through grants distributed by the Secretary in the FY1998 budget, has the potential to make a substantial contribution to reduce the problem of diabetes among minorities.

EXPAND INFANT MORTALITY PREVENTION ACTIVITIES AND SIDS CAMPAIGN.

We agree that expanding the Healthy Start Program, as mentioned in your memo, to target new minority communities would be one effective way of moving forward in this area. We are unclear whether new dollars would be necessary for this expansion. We are also interested in discussing other areas that promote these goals. We are also interested in expanding the "Back to Sleep" campaign, which you also mention in your memo with a special target to minorities, including targeting local communities, churches, grandparents, and other outreach efforts.

AIDS. We agree with the goals outlined in your memo, particularly with regard to increasing the percentage of minorities who are aware of their HIV serostatus and receive early access to primary care and other treatment. Consistent with these goals, we are interested in a demonstration that we recently learned the Department is considering as part of a potential response to the Vice President's request to have HCFA look into the feasibility of an AIDS Medicaid expansion. The proposed demonstration would implement a targeted outreach to high risk and HIV populations as well as a focused coordination of care effort across all programs treating HIV patients in a number of selected cities. We are also interested in discussing whether it makes sense to increase treatment programs such as ADAP, with a special emphasis on minority populations.

IMMUNIZATIONS. We do not have any specific suggestions in these areas, but are interested in ideas the Department or OMB has in ways to reduce the disparities. While we have made substantial progress in increasing immunization rates among children, we are interested in discussing specific initiatives that would meet your goals of increasing immunization rates for adults. We are also interested in discussing whether it is necessary to pursue new ways to better target minority children.

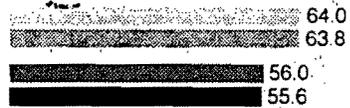
KEEPING TRACK

Race and Health: Differences Remain

Incidences of death and sickness from many diseases are subsiding, but gaps between the nation's whites and blacks persist.

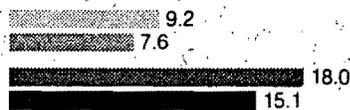
YEARS OF HEALTHY LIFE

(These figures are for 1990 and 1994)



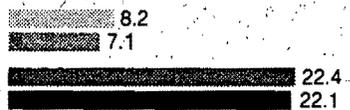
INFANT MORTALITY

for every 1,000 live births



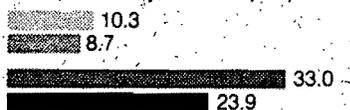
MATERNAL MORTALITY

for every 100,000 live births



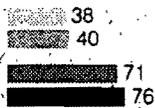
TUBERCULOSIS

cases for every 100,000 people



DIABETES-RELATED DEATHS

for every 100,000 people



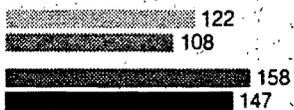
ALL FORMS OF CANCER

deaths for every 100,000 people



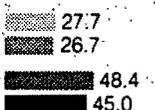
HEART DISEASE

deaths for every 100,000 people



STROKE

deaths for every 100,000 people



Source: Department of Health and Human Services

The New York Times

Cancer Society said, black men's death rate from cancer rose 62 percent, compared with 19 percent for all American men. A gap in the incidence of prostate cancer has narrowed. But the incidence is 30 percent higher for black men, and 66 percent survive for five years, compared with 81 percent of white men.

In general, the nation has realized declining death rates from leading killers like heart attack, stroke and cancer. But blacks still suffer those and other disabling conditions sooner than whites.

As a result, new research sponsored by the National Institute for Aging shows that blacks enjoy 56 years of reasonably good health, 8 years fewer than whites and Hispanic-Americans. In an institute survey, one-third of all blacks from 51 to 61 described their health as fair to poor, compared with one-fifth of all whites of the same ages.

Kenneth G. Manton, director of the Center for Demographic Studies at Duke University, who wrote an analysis of the survey, said: "If you look at the total population, you find a significant decline in chronic disability and institutionalization for people 65 and older. But if you break it down among blacks and whites, you find almost all the improvement is among whites."

Concern about the gap has entered White House planning for Mr. Clinton's last two years in office. It has risen with experts' doubts that the enactment last year of a five-year \$24 million plan to provide care to half the 10 million uninsured children would help reduce the disparities.

Administration officials expect Mr. Clinton, in his budget message, to ask for additional money to im-

prove minority groups' health. In addition, the officials say, he could ask for revisions of Government health programs so that additional people like nurses and physicians in minority communities join in working on the stubborn roots of the gap.

The issue is also entering other arenas. The President's advisory board on race, which has been dwelling mostly on discriminatory barriers to economic opportunity, has begun soliciting testimony on health.

Dr. Berwick said he and other members of the health commission were urging the commission to include a proposal to close the gap in the panel's final report in March.

To curry support to close the gap, the President is likely to define the issue in terms of minority health, not simply black health.

Other minority groups suffer from some diseases more than blacks. Indians have higher levels of diabetes. Hispanic-Americans tend to suffer more fatal and disabling strokes. Puerto Rican children have the highest incidence of asthma.

The C.D.C. reports that in 1996, tuberculosis among Asian-Americans was nearly 15 times higher than among whites and nearly twice the level for blacks.

But as the largest minority group and the one with the highest death rates from most diseases, blacks arouse the most concern.

"There is a minority group that is very disadvantaged with respect to health, and that's African-Americans," said Samuel H. Preston, a demographer and dean of the School of Arts and Sciences at the University of Pennsylvania. "It's not a minority problem. It's a black problem."

The intractability of the gap is

stirring searches for explanations beyond the conventional one of disproportionately low income. Hispanic-Americans, too, are relatively poor and are much less likely to have health insurance than any other group. Yet the C.D.C. finds that they stay healthy longer than non-Hispanic whites, as well as blacks.

Research has shown slight, apparently genetic, predispositions among blacks for prostate cancer, sickle cell anemia and underweight births. But analysts say the major disparities arise less from inherent differences among races than from attitudes toward the races and unequal care.

A study in October in The New England Journal of Medicine suggested something peculiarly American to being black and unhealthy beyond genes. For the study, two neonatologists in Chicago, Drs. James Collins and Richard David, surveyed the birth weights of all children born in Illinois from 1980 to 1995. They isolated the lowest-risk group of mothers, from 20 to 39, who were college educated, married to college-educated men, had prenatal care in their first trimesters and had no prior miscarriages or stillbirths.

The researchers found that 2.4 percent of the 12,361 American-born white mothers delivered underweight babies, compared with 3.6 percent of 608 mothers living in Illinois and born in sub-Saharan Africa, and 7.4 percent for American-born black mothers.

"These findings discredit the genetic theory of race as it applies to birth weight," the doctors said in a paper presented in November to the annual meeting of the American Public Health Association. "To understand this thing called race, we must turn our attention to the institutions and attitudes which perpetuate and justify unequal treatment of people on the basis of their physical appearance, language or culture."

In hospitals and clinics, said Sara Rosenbaum, director of the Center for Health Policy Research at George Washington University here, blacks often receive worse care than whites. "When you take black and white Americans," Ms. Rosenbaum said, "and exactly the same situation like being hospitalized for a heart attack and having the same insurance, the chance that the black patient will get the advanced care is much less than it is for the white patient. The medical system appears to treat them differently."

Analysts say solutions require attention to the health conditions of the very young, before the effects of poverty, toxic environments, bad diets, violence and untreated disease.

"Policy that only deals with people in their 50's is going to have a minor impact on eliminating differences because a series of health shocks has happened already," said James P. Smith, a senior economist at the Rand Corporation who testified this month before the race commission.

Policy goals should also change, said Dr. Berwick in Boston.

"It isn't enough to say we're going to close the gap by equalizing services," he said. "I don't think that's the heart of the problem. It's not equality of access. It's equality of result that we should seek."

2/2

Health Gap Grows, With Black Americans Trailing Whites, Studies Say

By PETER T. KILBORN

WASHINGTON, Jan. 24 — A robust economy and years of Government pressure have helped move minority groups closer to the mainstream. But when it comes to health, studies show a stubborn, daunting and in some respects growing disparity between black and white Americans.

For decades, blacks have suffered higher death rates from nearly all major causes. Although life expectancy has increased for all groups, differences persist. And Government and academic research shows a widening gap between blacks and others in the incidences of asthma, diabetes, major infectious diseases and several forms of cancer.

The Federal Centers for Disease Control and Prevention reports that from 1980 to 1994 the number of diabetes cases rose 33 percent among blacks, three times the increase among whites. The gap in cases of infectious diseases has grown by the same magnitude.

With breast cancer, the C.D.C. reports that from 1990 to 1995 the death rate for all women fell 10 percent, from 23.1 per 100,000 to 21. But black women's higher rate did not budge from 27.5 per 100,000.

The erosion of black Americans' health in relation to Americans at large stands in stark contrast to many blacks' advances in areas like jobs, education and housing that three decades of civil rights laws have helped promote.

In the economy of the 1990's, poverty among blacks has shrunk, and gaps in income have narrowed. Sociological barriers to economic progress like a high teen-age pregnancy rate have receded, too.

But blacks often receive less, and worse, health care than whites, analysts say, meaning that they are sicker than whites and typically die at about 70, six or seven years earlier than whites.

"We have a two-tiered health care system," said Dr. Randall Morgan, an orthopedic surgeon and a former president of the predominantly black National Medical Association.

Limited education, violence and addiction remain partly to blame. But Clinton Administration officials and analysts of health systems say they are finding growing evidence that race, discrimination and social and cultural factors influence the care people receive and, consequently, their health.

The chief White House adviser on health issues, Chris Jennings, said economic status was a big source of the gap. "But even if you control for that, race is huge," Mr. Jennings said. "If you pull out education, race is still huge."

The White House is grappling with new ways to address the problem, most likely in the President's budget proposal early next month. In response to a White House request, officials of the Department of Health and Human Services and the Health Care Financing Administration said they were compiling proposals to try to eliminate the gap after 2000.

Dr. Donald M. Berwick, a pediatrician in Boston and a member of President Clinton's commission on health care quality, said: "Tell me

someone's race. Tell me their income. And tell me whether they smoke. The answers to those three questions will tell me more about their longevity and health status than any other questions I could possibly ask. There's no genetic blood test that would have anything like that for predictive value."

The growth of managed care, experts said, has had little effect. "The more we hear about the problems in the health care delivery system and managed care, the more the issues of minorities stand out," said Bailus Walker, health policy director for the Joint Center for Political and Economic Studies, which focuses on blacks.

Administrations since the 60's have been aware of the gap and have started dozens of programs, committees and conferences to tackle it.

The Department of Human Services has an Office of Minority Health, which among other activities publishes a newsletter, Closing the Gap. The department compiles ambitious annual reports on progress toward goals for 2000 to prolong healthy lives and reduce the disparities.

But the results are mixed. For many conditions that disproportionately touch blacks, including asthma, obesity, homicide, maternal mortality, diabetes and fetal alcohol syndrome, the report published in October shows the incidences not only falling short of the goals but also slipping in relation to the conditions in the late 80's and early 90's, on which the goals were based.

Dr. Morgan said Government attempts to reduce the gap were modest and subject to sporadic financing. "We get a program, and then it's over," he said. "We can't get a sustained effort. The tragic thing is it's costing America more and more every day to have the premature babies — not the ones who die — who go on to drain the health system's resources."

Public health programs begun in Mr. Clinton's tenure have made little

An acute racial disparity in cases of asthma, cancer and infectious diseases.

more headway against the gap than those of prior Administrations, including Medicaid, the insurance program for the poor, and Medicare, the program for the elderly.

Programs that pay for prenatal care for mothers and nutrition and immunization for children have helped many additional children survive infancy. But deaths of black mothers in childbirth, although rare, jumped 48 percent from 1987 to 1995 (the rate soared in the late 1980's), compared with 7.6 percent for all mothers. And blacks still have two times the infant mortality rate of whites, a gap that has not changed in at least a decade.

Since the early 60's, the American

Racial Health File

The New York Times

MONDAY, JANUARY 26, 1998

21-

File Race

Health

American Heart Association
 Fighting Heart Disease
 and Stroke



Heart & Stroke Fax COVER SHEET

- ♥ Cardiovascular diseases, including heart attack and stroke, remain the No. 1 killer in the United States.
- ♥ About 1 in 4 Americans suffer from cardiovascular diseases at an estimated cost of \$138 billion in medical expenses and lost productivity in 1995.
- ♥ To fight these killers the AHA invests in research, education and community service programs.

Office of Communications and
 Advocacy
 1150 Connecticut Ave., N.W.
 Suite 810
 Washington, D.C. 20036
 Tel: (202) 785-7900
 Fax: (202) 785-7950

Date: 12/5/97

Time:

To: Sarah Braucki

Fax: (202) 456-5557

From: Diane Canova
 Office of Communications and Advocacy

Phone: (202) 785-7912

Fax: (202) 785-7950

Number of pages including cover sheet:

3

Message: Per your conversation yesterday
 with Martha Hall

Confirmation: yes no



Office of Communications and Advocacy
1150 Connecticut Avenue Northwest, Suite 810
Washington, D.C. 20036
Tel 202 785 7900
Fax 202 785 7950

December 5, 1997

Ms. Sarah Bianchi
Domestic Policy Council
Executive Office of the President
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Sarah:

This is a follow-up to your conversation yesterday with Dr. Martha Hill, American Heart Association President, regarding a White House proposal to increase the Centers for Disease Control and Prevention's cardiovascular disease and stroke education and prevention efforts among minority populations.

The American Heart Association encourages the President to call for significant additional funding to CDC to expand state public health efforts to increase awareness of the risks of heart disease and stroke and to implement comprehensive prevention programs targeting minority populations. We believe these efforts should focus on the prevention of cardiovascular diseases and stroke through discouraging of tobacco use, promoting physical activity, and encouraging healthy eating, and include other risk factors, as appropriate.

Regarding your request for names of potential AHA spokespersons to support the President's proposal, here are several persons whom Martha Hill has identified as excellent people to contact.

Charles K. Francis, M.D.
Director, Department of Medicine
Harlem Hospital Medical Center
College of Physicians and Surgeons
506 Lenox Avenue, Room 14101
New York, NY 10037
Phone: (212) 939-1401
Fax: (212) 939-1403

George Mensah, M.D.
Associate Professor of Medicine
Director of Hypertension
Medical College of Georgia
Augusta, GA 30912
Phone: (706) 721-7353
Fax: (706) 721-7136

Chairman of the Board
Marilyn Hann

President
Martha N. Hill, R.N., Ph.D.

Chairman-Elect
Edward F. Hines, Jr., Esq.

President-Elect
Valentin Fuster, M.D., Ph.D.

Immediate Past Chairman of the Board
David A. Ness

Immediate Past President
Jan L. Breslow, M.D.

Secretary
Henry Morris, Jr., Esq.

Treasurer
Mack S. Linabaugh, Jr.

Vice Presidents
Hugh D. Allen, M.D.
C. William Balke, M.D.
William R.H. Broome, Esq.
Joy S. Frank, Ph.D.
Donald W. LaVan, M.D.
Janet Maxson, B.S.N./TNP/PA-C
Lorrie Peterson, R.N.
Lawrence B. Sadwin
Joan Ware, R.N., M.S.P.H.

Chairperson, Advocacy Coordinating Committee
J. Walter Sinclair, Esq.

Chairperson, Marketing and Communications Coordinating Committee
John W. (Jack) Bates

Chairperson, Scientific Publishing Committee
Elizabeth G. Nabel, M.D.

Chairperson, Scientific Sessions Program Committee
Rose Marie Robertson, M.D.

Members-At-Large
R. Wayne Alexander, M.D., Ph.D.
Claire M. Bassen
William J. Bryant, Esq.
Vincent J. Bufalino, M.D.
Louis L. Creger, M.D.
Charles Dennis, M.D.
Ann E. McPartlin
Nancy Houston Miller, R.N.
J.E. Chavez Paisley
Lynn A. Simms, M.D., Ph.D.
Henry M. Sondheimer, M.D.
Janet O. South
Donald A. Trimble, C.P.A.
Jessie G. Wright, M.S., R.D., L.D.

Executive Vice President
Dudley H. Hafner

Senior Vice President Corporate Operations
Walter D. Bristol, Jr.

Senior Vice President Marketing
Jo A. Diehl

Senior Vice President Communications and Public Advocacy
Brigid McHugh Sumner

Senior Vice President Science and Medicine
Rodman D. Starke, M.D.

Senior Vice President Field Operations
M. Cass Wheeler

Vice President, Corporate Secretary and Counsel
David Wm. Livingston, Esq.

Roxanne Rodney, M.D.
Assistant Professor of Clinical Medicine
Associate Director of Nuclear Cardiology
College of Physicians & Surgeons of Columbia University
630 West 168th Street
New York, NY 10032
Phone: (212) 305-9933
Fax: (212) 305-4648

Jessie G. Wright, M.S., R.D., L.D.
President, Nutrition Management Services, Inc.
3025 University Avenue, Suite C-1
Columbus, GA 31906
Phone: (706) 563-5783
Fax: (706) 327-5985

We look forward to working closely with you as this proposal moves forward. If there is additional information we can provide, please contact me at (202) 785-7912.

Sincerely,



Diane M. Canova
Vice President of Advocacy

cc: Martha Hill
Lisa Daily, CDC

Race Health File

MEMORANDUM

November 25, 1997

TO: Chris J.
FR: Sarah B.
RE: Race and Health

Why the \$30 million not enough:

- First and foremost, this is simply not enough money for a Presidential initiative. (This really is the main problem). The West Wing is counting on this issue as one of their main race initiatives and this is simply not enough to get it validated.
- Grant program will target 30 communities and teach us better how to address these problems -- giving us models so that the entire Department can integrate new ideas that work. This is a long term process though before we actually get results but we teach us critical information we do not know and will be critical if we are ever going to eliminate the disparities.
- However, there are many existing programs that have not adequately focused on these disparities and have not reached out to enough underserved communities. Giving these programs new dollars specifically to work on this problem would be helpful -- particularly if we are going to reduce disparities during President's time in office.
- Moreover, this will make the President's race initiative a national one -- rather than just focused on particular problem. This is necessary if we are to reduce rates.
- There are some CDC programs that have gotten validation from the advocacy groups and experts, such as the breast and cervical screening program that have indicated their willingness to use new dollars to reach out specifically to new dollars. We believe that these focused initiatives could be effective in reducing rates.
- Finally, the bulk of the money in our proposals are in cancer and heart disease -- both areas the West Wing (VP, FLOTUS) has indicated spending money in. It is alarming that there is no national prevention program for heart disease when it is the nation's leading killer.
- **Again Josh's staff knows these programs better than we do. We would like to work with Richard to figure out how to spend an additional \$50 - \$70 million to best reach this population and make this initiative credible.**
- We have a few proposals that sum up to a \$70 million increase. However, they could be scaled back

**Race and Health Initiative
HHS PROPOSALS**

CJ -- this is a summary of what John Callahan sent. The basic concept behind it is that of all of the spending proposed in these areas, this is the amount that would have been allocated for minorities.

INFANT MORTALITY: \$111 million. Of the increases HHS proposed in areas related to infant mortality, \$111 million was intended to be dedicated to increases in programs or initiatives that primarily affect minorities. This includes the Back to Sleep Campaign, a portion of the Children's Health Initiative, Healthy Start.

CANCER SCREENING AND MANAGEMENT : \$2 million increase in CDC and ACHPR to increase cancer screening.

HEART DISEASE AND STROKE: \$30 million. Between increases in CDC, HRSA, NIH, and AHCPR, \$30 million was intended to be specifically to minority communities. Some was to be targeted to prevent tobacco specifically in minority communities.

DIABETES: \$8 million. Including expansion of CDC education programs to 12 to 14 states with a particular emphasis on minority populations and IHS Diabetes and Treatment Grants.

AIDS: \$59 million increase in AIDS, including Ryan White programs for cities, pediatric AIDS options, CDC's HIV/AIDS prevention/outreach.

IMMUNIZATION: \$10 million in programs at HRSA, CDC, NIH, and IHS. CDC will focus on prevention of influenza, Hepatitis and other preventable diseases in adults.

POSSIBLE OPTIONS

HEART DISEASE

- **A Nationwide Education Campaign.** This campaign -- which could have an special emphasis to target minority communities -- would educate health providers and high risk populations about how to prevent cardiovascular disease and stroke. It would stress the importance of keeping blood pressure under control, the need for physical activity, and reducing tobacco use. It could include PSAs and other national-based efforts (such as the President or the Secretary launching healthy heart walks in major cities) as well community-based efforts based on successful outreach models (such as "Search Your Heart"-- a church-based heart health program for African-Americans run by the American Heart Association); There is currently no national prevention initiative on heart disease.
- **Coordinated Cardiovascular Efforts in Every State.** Another aspect of this initiative could include funding for state or local health departments to begin a cardiovascular outreach program, just as many of them have efforts to reduce infant mortality, AIDS, and other major health problems. With this new stable source of funding, state and local health departments could bring together community-based organizations and coordinate state and local prevention activities. They could be directed to have particular focus on minority health;

Total: \$20 million

CANCER MANAGEMENT

Breast and Cervical Cancer Prevention. Increase funding at for this CDC program to target specifically to minorities (CDC has told me they can do this).

Colorrectal Screening. A major screening program for low-income and high-risk populations -- similar to the one for breast and cervical cancer at the CDC -- combined with a national campaign to educate the public and health care providers about the importance of screening would encourage more Americans to get screened for this cancer. African-Americans are more likely to be diagnosed with it and more likely to die from it and mortality trends indicate that the gaps between blacks and whites are widening. There is currently no screening program.

Cancer Outreach Campaign. Education campaign specifically minority communities to inform them about the latest knowledge about cancer, including prostate cancer, colorectal cancer, and breast cancer.

These proposals have been validated by the American Cancer Society as a high priority for improving prevention.

Total: \$30 million

DIABETES. New funding for the National Diabetes Education Program which would have an emphasis on targeting minority communities. We believe that this new IHS increase, in addition to the \$30 million per year for Native Americans through grants distributed by the Secretary in the FY1998 budget, has the potential to make a substantial contribution to reduce the problem of diabetes among minorities.

Total: \$5 - \$10 million

EXPAND INFANT MORTALITY PREVENTION ACTIVITIES AND SIDS CAMPAIGN.

We are also interested in expanding the "Back to Sleep" campaign, which you also mention in your memo with a special target to minorities, including targeting local communities, churches, grandparents, and other outreach efforts.

(CJ this may have survived the passback. I am not sure).

Total: \$10 million

AIDS.

Sandy tells me that we can allocate some of the possible increases in AIDS that they might get from the Presidential initiative pot. We would like to target at least \$10 million of the ADAP money and prevention money particularly to the minority community. \$10-\$15 million.

TOTAL: \$70 MILLION

President's Initiative on Race: The Department of Health and Human Services Summary Data

The attached table and narrative highlights FY 1998 and FY 1999 HHS spending targeted to reducing disparities in health outcomes by the six goal categories of the President's Race Initiative. We have incorporated data from each of our Operating Divisions to provide a clearer picture of how we arrived at the total figures by goal. Furthermore, for ease of review, total amounts are broken out by mandatory and discretionary spending.

Notes to Accompany Funding Tables

The attached table highlights FY 1998 and FY 1999 OPDIV funding to reduce disparities in health outcomes by the six goal categories of the President's Race Initiative, broken out by mandatory and discretionary spending. FY 1998 numbers are based on the Conference Action and the FY 1999 levels are based on the FY 1999 Budget Requests to OMB. Explanations of numbers are provided below.

Discretionary Spending

Reducing Disparities in Infant Mortality including death from Sudden Infant Death Syndrome

The FY 1999 request totals \$864.3 million in discretionary funds from HRSA, CDC, AHCPR, and NIH to reduce disparities in infant mortality for minority populations. This represents an increase of +\$110.9 million over the FY 1998 enacted amount of \$753.4 million. Increases are due to requests for the Secretary's Children's Health Initiative (HRSA - Healthy Start and Health Centers), and Emerging Infectious diseases and food safety (CDC). HRSA's total FY 1999 budget request for health centers supports approximately 100 new sites. A significant portion of these increases will be used to expand health centers to uninsured and underserved residents living near the U.S./Mexico border. Another key element of the FY 1999 request would be to continue the reduction of infant mortality by increasing access to comprehensive health care services for women of childbearing age and parenting women, in addition to strengthening the community-based and family-centered infrastructure to support effective service systems. For example, the Maternal and Child Health (MCH) Block Grant provides outreach activities to help enroll Medicaid-eligible children in a comprehensive Medicaid health home. Other MCH Block Grant efforts include promoting population-based public health initiatives to assure healthy community, such as the "Back to Sleep Campaign," injury prevention, and newborn hearing screening.

Reducing Disparities in Breast and Cervical Cancer Screening and Management

The FY 1999 request totals \$113.6 million in discretionary funds from the CDC, NIH, and AHCPR to reduce the disparities of health outcomes in minority populations. These funds support the Breast and Cervical Cancer Prevention program of the CDC and a variety of crosscutting projects in NIH and AHCPR. The request represents an increase of +\$2 million over the FY 1998 enacted amount of \$111.6 million. Funds will be used for an aggressive response, including delivery of screening services to underserved women. These services will support activities at the State and national level in the areas of screening referral, quality assurance, public and provider education, surveillance, and partnership development. CDC's strategic planning efforts for FY 1998 and FY 1999 will continue to expand the network of non-traditional partnerships within communities to increase access to screening services.

Reducing Disparities in Heart Disease and Stroke

The FY 1999 request targets \$250.2 million in discretionary funds from CDC, HRSA, NIH, and AHCPR to reduce disparities in heart disease and stroke. This represents an increase of

+ \$30.8 million over the FY 1998 enacted amount of \$219.4 million. Increases in CDC's Heart Disease and Health Promotion program will prevent tobacco use. Increases in NIH and AHCPR will support a variety of crosscutting projects, such as examining therapies to lower blood pressure to effectively reduce stroke and heart attacks, and examining the treatment of arrhythmia with defibrillators to restore normal heart rhythm. Among CDC's comprehensive heart disease and health promotion programs, funds to support surveillance and public education programs will continue to be directed to high-risk minority populations. Special emphasis would be placed on reduction of tobacco use among minority youth as part of an overall heart disease prevention effort.

Reducing Disparities in Diabetes-Related Complications

The FY 1999 Budget request supports \$178 million of discretionary funds in IHS, CDC, NIH, AHCPR, and HRSA to be targeted towards this goal. This represents an increase of +\$7.9 million over the enacted amount of \$170 million¹. This Goal encompasses such programs as the Model Diabetes Prevention Program (IHS), Diabetes Treatment and Prevention Grants (IHS), NIH research on diabetes. The increase is attributable to the IHS Model Diabetes Program and increases in CDC, NIH, and AHCPR diabetes related programs. The IHS Diabetes Treatment and Prevention Grant totals \$33 million in FY 1998 and FY 1999; primary funding through FY 2002 is provided by the Balanced Budget Act. Funds will enable IHS to provide service grants to tribes, IHS facilities, and Urban Indian health centers for the prevention and treatment of diabetes. For example, grantees will test community-based intervention strategies designed to increase knowledge about preventing primary diabetes (i.e. reducing obesity). CDC currently supports five comprehensive diabetes control programs. In FY 1998 CDC will expand these programs to reach 12-14 States, and to expand the active network of diabetes control programs in all five States.

Additional examples of activities funded include providing education to the most vulnerable populations with diabetes to prevent serious health complications, developing plans and strategies for Statewide diabetes control, and establishing partnerships with managed care organizations. Comprehensive activities also include helping State Medicaid programs develop and monitor quality outcome measures for diabetes care, launching public and physician education campaigns, and undertaking community-based programs to better measure the prevalence and type of diabetes among African American populations.

Reducing Disparities in AIDS Care Rates

The FY 1999 discretionary request includes \$1.13 billion in HRSA, CDC, NIH, SAMHSA, and AHCPR to reduce disparities in HIV/AIDS. This represents an increase of +\$58.9 million over the FY 1998 enacted amount of \$1.07 billion. Programs and services include HRSA's Ryan White programs for cities, States, drug purchases, primary care clinics, pediatric AIDS, Education and Training Centers, Dental Services and CDC's HIV/AIDS prevention/outreach

¹The IHS data reported for diabetes spending do not include amounts from the overall IHS health care delivery system, because the funds that support these activities come from several of the IHS sub-activities and cannot be delineated at this time.

program. They also include SAMHSA's efforts to reduce HIV infection related to injecting drug use through a wide variety of programs including Knowledge Development and Application, Targeted Capacity Expansion, and Substance Abuse Block Grants; NIH's research contributions; and AHCPR activities. A significant portion of this increase is attributable to the NIH budget request which focuses on innovative approaches to pathogenesis such as stimulating vaccines, important preventive strategies, and research and development of therapeutics. HRSA's increases focus on drug purchasing and primary care activities, such as in Ryan White Title III funds are requested to expand the early intervention services program to communities with the most alarming growth rates of HIV infection—HIV/AIDS is occurring increasingly among minorities. For example, the 49 Title I communities which are highly impacted by AIDS serve largely minority communities. Over 40 percent of those served are black and over 20 percent are Hispanic.

Reducing Disparities in Immunization Rates

The FY 1999 discretionary request of \$237.3 million represents an increase of +\$9.9 million over the FY 1998 enacted amount of \$227.3 million to reduce disparities in immunization rates between populations. These funds support immunization programs in HRSA, CDC, NIH, and the IHS' Viral Hepatitis and H. influenza Type B (Hib) project in Alaska. Increases over the FY 1998 enacted amount are attributable to increases in the IHS Alaska program. In CDC funds will enhance the prevention of needless morbidity and mortality due to vaccine preventable diseases in adults—vaccine coverage is lower among African American adults. CDC also proposes in FY 1999 to include the development of effective informational programs for health care providers, and the development of strategies to increase access to immunization services. NIH's attention will be focused on research to provide safer, more effective vaccines.

Mandatory Spending

As the basis for minority spending estimates, HCFA uses the data prepared for the 1998 Moyer tables provided to Congress, and, in order to break out spending by goal, the latest actuarial data—FY 1995 Medicare and Medicaid benefits by disease. Total Medicare and Medicaid expenditures for FY 1995 are used to develop a percentage of benefits spent by disease category, which is then applied to the minority health and assistance number. *This approach assumes that spending on minority health occurs in the same proportion as in the population as a whole.* Medicaid data for Goal 6 contains data from the CDC as well as HCFA. Funds directed towards minority communities spent in CDC's VFC (Vaccines for Children) program are contained in this total.

Mandatory spending totals which combine Medicare and Medicaid and are provided by HCFA carry the following limitations: Stroke data is not available in Medicaid and Heart disease data is not available in Medicare; Medicaid does not break out a diabetes number; Medicare numbers for AIDS are estimated from the 1996 Moyer numbers; and Breast and Cervical Cancer data reflect only Mammogram and Pap Smear screening and diagnostics data.

President's Initiative on Race

Discretionary Funding

(\$ in thousands)

	FY 1998 Enacted	FY 1999 Budget Request	Increase
Reduce Disparities in:			
Infant Mortality	753,398	864,306	110,908
Breast and Cervical Cancer	111,600	113,600	2,000
Heart Disease and Stroke	219,372	250,210	30,838
Diabetes	170,119	178,040	7,921
AIDS	1,075,690	1,134,597	58,907
Immunization	227,337	237,294	9,957
Total	2,557,516	2,778,047	220,531

30,000

160,000

4

134,000

Lead

Mandatory Funding

	FY 1998 Enacted	FY 1999 Budget Request	Increase
Reduce Disparities in:			
Infant Mortality	2,858,111	3,070,368	212,257
Breast and Cervical Cancer	56,905	61,397	4,492
Heart Disease and Stroke	2,205,388	2,372,348	166,960
Diabetes	876,330	946,436	70,106
AIDS	703,993	757,042	53,049
Immunization	192,091	211,365	19,274
Total	6,892,818	7,418,956	526,138

1/ Totals include \$45.726 million duplicated within the HRSA AIDS and infant mortality categories.

File Race + Health

**RACE AND HEALTH MEETING
OPL MEETING
November 7, 1997**

I. Purpose: We have been working the Dept to develop an initiative to reduce disparities in race and health. We wanted to get a preliminary read as to how best to get validation from the minority community for this initiative and how to fine tune the initiative so that these new investments do the most possible to reduce the disparities.

We believe that the investment of the community is essential to the success of this initiative.

At the same time, of course, we want to keep the news angle of this announcement.

II. Initiative: We have identified six areas to target this initiative: AIDS, diabetes, cancer, heart disease and stroke, infant mortality, immunizations. These do not represent all areas for all minority groups where there are disparities. (i.e Sickle Cell Anemia for African-Americans). However, we have chosen these areas because there seem to be disparities in more than one minority group.

The initiative has a three major aspects:

(1) Dedicating New Dollars in FY 1998 to Work Focus on Reducing These Disparities: HHS has analyzed the current funding they are likely to get from the Labor/HHS bill to find what new programs and grants are currently planned or can be allocated specifically for minorities. These include for example,

New SIDS Outreach to Minorities; NIH will launch a \$2 million new outreach effort targeted to racial and ethnic communities to reduce infant deaths from SIDS.

A new focus in the CDC National Diabetes Education Program to focus on minority populations.

Ryan White (AIDS) Program will now ask states to report how many minorities they serve and what they are doing to reach out to minority populations.

(2) New Healthy Life Program: This program would be \$450 million over five years to fund grants to communities to develop an innovative approach to reducing one of the six race disparities. HHS would work closely to provide technical assistance to these communities and to collect good data. HHS would

also use successful models done in these communities to apply to HHS programs or develop a nationwide model to help reach the 2010 goal of reducing disparities in race and health.

One thing that we think may be particularly important is how these grants are distributed. Perhaps there should be an Advisory Board with members of minority community -- or some other way to include/invest the community in this effort.

(3) New Efforts in the President's FY 1999 Budget. We are also having discussions with HHS and OMB about other new funding in the FY99 budget which could be dedicated to these purposes. Budget is tight and it would likely only be modest increases in existing programs to specifically target minority population or to reevaluate how programs can better serve minority populations.

III. The Goal: The goal of this initiative is to reduce all race disparities in these areas by 2010. There are interim goals -- such as reaching the *Healthy Goals 2000* goals identified by HHS by the year 2000 and following progress closely.

III. Questions:

What is the best way to reach out to invest the community, without undermining news value?

Are there major problems with this policy approach that you notice rg. These efforts mostly identi



OTU Race/Health

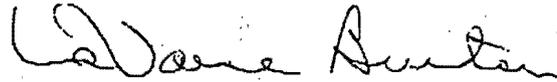
October 31, 1997

NOTE TO CHRIS JENNINGS:

Subject: President's Proposed Minority Health Initiative

Attached is an unsigned copy of a memorandum to you from Bill Corr transmitting the materials on the HHS goals for eliminating health-disparities, and the proposed budget tables for FY 1998 and FY 1999 that we promised to send to you today.

Bill had to leave before he was able to sign the memorandum. We will forward a signed copy to you on Monday.



LaVarne Burton
Executive Secretary
to the Department

Attachment

D R A F T

October 31, 1997

MEMORANDUM TO CHRIS JENNINGS:

Subject: President's Proposed Minority Health Initiative

Attached is the material you requested on the Department's goals for closing the gap between minorities and whites in six key areas. The draft document outlines the context in which this would be announced to the public and to the media. It includes a one page summary that describes the proposed President's Minority Health Initiative and six Fact Sheets on each one of the priority areas with specific action steps for each area.

In addition, attached is the Fact Sheet on the proposed Healthy Life Grants in up to 30 communities that we discussed at our last meeting. The objective of the program is to demonstrate effective methods to reduce health disparities among minority populations in the six priority areas. Also included are two budget tables with proposed budget allocations for FY 1998 and FY 1999 that are categorized by each of the priority areas.

I look forward to discussing these materials with you at the meeting on Monday.

Unsigned

William V. Corr

Attachments

OVERVIEW AND FACT SHEETS
ON THE PRESIDENT'S PROPOSED MINORITY HEALTH INITIATIVE

DRAFT

PRESIDENT CLINTON ANNOUNCES MINORITY HEALTH INITIATIVE

Today, President Clinton ^{state the components (Healthy Life, Immediate action)} took a bold step forward in improving the health of all Americans by unveiling a comprehensive strategy for significantly raising the health status of America's minority populations. The President outlined a new health component to his Race Initiative that will close the gap between minorities and whites in six key areas of health. The President also announced that U.S. Health and Human Services Secretary Donna E. Shalala will oversee this initiative. The six areas are:

- Infant deaths
- Cancer screening and management
- Cardiovascular disease
- Diabetes
- HIV/AIDS infection rates
- Child and adult immunizations

^{in racial disparities by 2010.}
CLOSING THE GAPS. Minorities historically have not fared as well as whites when it comes to health status. From lack of access to health care to poverty to inadequate education and prevention efforts in minority communities, numerous factors impact lower minority health status in America. The President's plan targets the complete elimination of racial disparities in each of these areas of health by the year 2010, with near-term goals to be met in each area by the year 2000. The plan combines a specific series of action steps - activities that will occur over the next year - as well as a request to Congress to fund in next year's budget a series of demonstration projects that effectively address these disparities in local communities.

^{A NEW SHIP also}
PARTNERS WITH LOCAL COMMUNITIES. As a follow-up to the specific action steps, the President will ask Congress for \$450 million over five years to fund a series of "Healthy Life" grants in 30 local communities, beginning in Fiscal Year 1999. ^{have new grants for new efforts to} The Clinton Administration will utilize these grants to provide additional resources to local communities that are significantly reducing racial health disparities in at least one of the six priority areas. Through the grants, the Administration ^{will} hopes to help build and solidify communitywide partnerships, as well as cultivate ideas from around the country about successful strategies for eliminating health disparities. In essence, the communities selected for the grants will test broader approaches to reaching the 2010 minority health goals.

^{Proposing}
BUILDING ON THE PRESIDENT'S INITIATIVE. The plan unveiled today is part of the historic, year-long initiative on race announced by President Clinton in June to start a national dialogue about race and address America's racial divisions with constructive dialogue, study and action. While other aspects of the Race Initiative will help achieve racial harmony through improved housing and job opportunities, a fairer judicial system, and better educational opportunities, the President's minority health initiative is designed to bring about racial harmony by giving minority Americans the same chance as all others to lead long, healthy lives.

^{that will then be applied throughout the Dept}
 The President also announced new actions in FY 1999 Budget etc.

TAKING IMMEDIATE STEPS TO IMPROVE MINORITY HEALTH OUTCOMES. Today the President is announcing new actions that existing programs are taking to improve health disparities, for example

NH's lunch
 a new program to target SIDS - (cite)

Goal 1: INFANT DEATHS

To shorten, let's state goals together.

LONG-TERM GOAL: Eliminate the disparities among racial and ethnic groups in the rate of infant deaths *by year 2010*

BACKGROUND: Infant death rates among Blacks, American Indians, Alaska Natives, Puerto Ricans, and Native Hawaiians in 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for Blacks, for whom the infant death rate (14.2 per 1,000 in 1996) is nearly 2½ times that of white infants (6.0 per 1,000 in 1996).

in past decade?
Infant death rates have been declining, but the decline for a number of racial and ethnic groups has lagged significantly behind the overall national trend. Differences in the rates of low birth weights and pre-term births are major factors in these disparities, with causes ranging from poor prenatal care to behavioral factors such as substance abuse and poor nutrition. And while there also has been a reduction in deaths due to Sudden Infant Death Syndrome (SIDS), SIDS still accounts for about 10 percent of all infant deaths in the first year of life. The SIDS rates among some American Indian and Alaska Native populations (*figures not exact due to lack of data*) range from three to four times the rate for white infants (71 per 1,000 live-born infants), while for African American infants (178.6 per 1,000) it is nearly 2½ times the rate for white infants.

a grant program to
The Health Resources and Services Administration (HRSA) is expanding a number of programs targeted to reducing infant mortality in minority communities, including the recent announcement of \$50.6 million in new Healthy Start awards to 40 high-risk, predominantly minority communities. The Healthy Start program will support implementation of community-devised strategies to reduce infant mortality. *in FY1997*

These grants will — — — specifically (do what to help infant mortality)
NEAR-TERM GOAL: Reducing the gap for Blacks (which have the greatest disparity among groups in terms of infant death rates) by at least 20 percent from their 1996 rate by the year 2000 -- or from 14.2 per 1,000 to 12.5 per 1,000 -- as prescribed under the *Healthy People 2000* objectives, while improving the capability to gather data in this area concerning other ethnic and racial minorities. *not new goal*

lots of problems for why only goals of minority
IMMEDIATE ACTION STEPS:

to reduce infant deaths
1. **Mississippi Delta Project.** HRSA will work with community leaders in the 10-county Mississippi Delta region, which experiences infant death rates that are among the highest in the nation -- to develop a comprehensive strategy to improve child and infant health and reduce the overall burden of disease. All of HRSA's bureaus will be involved in a coordinated effort to provide a model for identifying regional health problems and orchestrating a response. The initial \$100,000 grant for community planning will be awarded in late 1997.

New to reduce SIDS in minority comm
2. **SIDS Outreach.** The National Institutes of Health in December 1997 will launch a \$2 million new outreach effort targeted to racial ethnic communities in an effort to reduce infant deaths from SIDS. This project will include new media efforts to reach non-English-speaking parents,

DRAFT

outreach to health professionals who serve primarily minority communities, and better use of ethnic radio stations to raise parental awareness of what we know about SIDS.

See actions

Goal 2: CANCER SCREENING AND MANAGEMENT

LONG-TERM GOAL: Eliminate disparities that exist in cancer screening and management by 2010.

BACKGROUND: Cancer is the second leading cause of death in the United States, accounting for more than 500,000 deaths a year. Many minority groups suffer disproportionately from cancer. Black men, for example, have a death rate (232.7 per 1,000) from cancer that is more than 40 percent higher than white men (154.2 per 1,000) as well as a death rate from lung cancer that is more than 50 percent higher than that of white men (80.5 per 1,000 vs. 53.7 per 1,000). Cervical cancer death rates among Black women (5.2 per 1,000) and Hispanic women (3.5 per 1,000) are higher than the overall U.S. rate (2.5 per 1,000).

Early detection and screening can reduce the risks of death from many forms of cancer -- a 30 percent reduction in the risk of death from breast cancer and nearly total elimination of the risk of death from cervical cancers. However, disparities exist among racial and ethnic groups not only in the incidence and death rates due to breast and cervical cancer, but also in the percentage of women who receive screening for breast and cervical cancers.

In 1994, the proportion of women age 50 and over who had received clinical breast examination and a mammogram in the previous two years was as follows: total -- 56 percent; white -- 56 percent; Blacks -- 56 percent; Hispanic -- 50 percent; American Indian/Alaska Native -- 53 percent; Asian/Pacific Islanders -- 46 percent. Similarly, the proportion of women age 18 and over who had received a pap test within the previous three years was as follows: total -- 77 percent; white -- 76 percent; Blacks -- 84 percent; Hispanic -- 74 percent; American Indian/Alaska Native -- 73 percent; Asian/Pacific Islanders -- 66 percent.

NEAR-TERM GOALS: By the year 2000, increase to at least 60 percent the proportion of women from all racial and ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the previous two years, and increase to at least 85 percent the proportion of all women aged 18 and older who have had a pap test within the past three years.

IMMEDIATE ACTION STEPS:

1. The Minority Women's Breast Cancer Initiative. Collaborative activities between the National Cancer Institute and the U.S. Public Health Service's Office on Women's Health will be supported to address research, service delivery, and education issues related to disparities in breast cancer incidence and mortality among women of color. The PHS Office of Women's Health will provide funding to organizations at the local level with a budget of \$2 million in FY 1998.

2. Increasing Female and Minority Recruitment to Cancer Care and Clinical Trials. Expansion of the National Cancer Institute's Community Oncology Program provides enhanced support for expanding clinical research in minority community settings, bringing state-of-the-art treatment and cancer prevention and control research to minorities in their own communities. Having already established a minority-enriched screening center with an African-American focus

Handwritten notes on the right side of the page: "evidence for cancer than other breast cancer", "major dispar. were that minority have later stage cancer", "higher death rates", "be more compelling", "what about other cancers?"

Handwritten note: "Timing? new?"

Handwritten circled number "2"



to the Prostate, Lung, Colorectal and Ovarian Trial, the NCI plans to add a second minority-enriched screening center in FY 1998, preferably with a Hispanic focus.

↳ not yet determined?

① **3. CDC Educational Partnerships.** The CDC will enter into cooperative agreements totaling \$15 million with 15 national organizations to promote prevention and education about breast, cervical, colorectal, and skin cancers. The partner organizations -- which will include the National Coalition of Hispanic Health and Human Services, the Association of Asian Pacific Community Health Organizations, the National Asian Women's Health Organization, and the National Caucus and Center on Black Aged, Inc. -- will build local coalitions and implement grassroots and community activities that can reach priority and underserved populations.

more specific when starting?

Goal 3: CARDIOVASCULAR DISEASE

LONG-TERM GOAL: Eliminate disparities in the death rates due to heart disease and strokes. *by 2010*

BACKGROUND: Cardiovascular disease, particularly heart disease and stroke, kills nearly as many Americans as all other diseases combined and is one of the major causes of disability in the United States. The age-adjusted death rate in 1995 for Blacks attributable to heart disease was 147 deaths per 100,000 people, compared to 105 per 100,000 for whites and 108 per 100,000 overall. And while the overall death rate for coronary heart disease declined by 20 percent from 1987 to 1995, the decrease for Blacks was only 13 percent. For strokes, the 1995 death rate for Blacks was 45.0 per 100,000, compared to 24.7 per 100,000 white people and 26.7 per 100,000 Americans overall.

Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high death rates from heart disease and stroke. Racial and ethnic minorities also have higher rates of hypertension and are less likely to undergo treatment for high blood pressure and to be screened for cholesterol.

do we need

example

NEAR-TERM GOALS: By the year 2000, reduce the heart disease and stroke death rates for Blacks by 25 percent from their 1995 level -- from 147 per 1,000 to 110.25 per 1,000 for deaths from heart disease and from 45 per 1,000 to 36 per 1,000 for deaths from strokes -- as prescribed by the Healthy People 2000 goals, while improving the capability to gather data in this area concerning other ethnic and racial minorities.

IMMEDIATE ACTION STEPS:

not new goals?

1. "Cardiovascular Health for Asians and Pacific Islander American Families." The National Heart Lung and Blood Institute will launch this program in FY 1998 to develop a model cardiovascular outreach program for selected populations of Asian and Pacific Islander Americans. A general approach will be developed that can be tailored to the specific culture, language, and traditional beliefs of the various Asian-American and Pacific Islander subpopulations. Funding for the project is \$350,000.

more specific about what model will be like.

2. Reduced Tobacco Use by Youth. Tobacco use is a major risk factor for cardiovascular disease, and reducing the proportion of youth who start smoking and encouraging smoking cessation are important preventive measures. The President has requested a total of \$58.7 million in FY 1998 for cardiovascular disease prevention activities at CDC, including those concerning tobacco and physical activity. Of that amount, \$12.64 million would be utilized for minorities.

make windows more specific

3. State-based Programs. In FY 1998, the CDC will initiate a state-based cardiovascular disease prevention program in states with high rates of cardiovascular disease. The funded states will reflect the disparities in cardiovascular disease rates and will have large ethnic or minority populations. These state programs will determine which groups are the most at-risk and will direct specific program interventions to reduce risk factors in these populations to levels at or

How the spec will be detailed to it. really. Specifically for

such as be those of the greatest

THS will use lessons learned in this
below the general population. This program will result in a national strategy for cardiovascular disease prevention through state-based programs. Funding for the program is estimated to be between \$2.7 million and 8 million.

*program
to
develop*

4. Cardiovascular Medical Education Web Site for Health Care Professional Who Care for Black Patients. By the summer of 1998, the NIH will launch this site, which will be used by members of the National Physicians' Network. The site will report on coronary heart disease in Blacks and provide specific treatment information in areas such as blood pressure, cholesterol, and preventive health behaviors and will provide heart-friendly recipes for favorite Black dishes.

which is (defining the)

Goal 4: DIABETES

LONG-TERM GOAL: Eliminate disparities in diabetes-related complications.

BACKGROUND: Diabetes is the seventh-leading cause of death in the U.S. It affects 16 million Americans, but the rate of diabetes-related complications varies among racial and ethnic groups. In 1995, the rate of lower extremity amputations among Blacks was 10.2 per 1,000 persons with diabetes, compared to a rate of 9.4 per 1,000 among all people with diabetes. The rate for end stage renal disease (kidney failure) between 1992-1995 was 3.0 per 1,000 persons with diabetes overall, compared to 2.4 per 1,000 whites, 5.2 per 1,000 Blacks, and 5.4 per 1,000 American Indians and Alaska Natives.

While the rates of prevalence and deaths from diabetes has remained the same or decreased for whites, they have been increasing among American Indians/Alaska Natives and Blacks. The prevalence rate among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for Puerto Ricans, Mexican-Americans, Cuban-Americans, Native Hawaiians and some subgroups of Asian Americans; but existing data do not currently allow us to monitor diabetes complications among Hispanics. *how to do*

Even with similarly insured populations such as Medicare recipients, Blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement, which are all signs of poor diabetic control.

NEAR-TERM GOALS: By the year 2000, reduce the rate for end stage renal disease among minorities by 65 percent from their 1995 levels -- or to 1.82 per 1,000 among Blacks and to 1.89 per 1,000 for American Indians and Alaska Natives; improve data collection and develop strategies to reduce diabetes-related complications among Hispanics; and to reduce lower extremity amputation rates from diabetes among Blacks by 40 percent from their 1995 levels to 6.2 per 1,000.

IMMEDIATE ACTION STEPS:

1. **Type 2 Diabetes Intervention Trial.** The National Institute for Diabetes, Digestive and Kidney Disease (NIDDK) is initiating a large multi-center (25 sites) randomized clinical trial of lifestyle and drug interventions aimed at preventing onset of type 2, or non-insulin dependent, diabetes in patients at high risk for developing the disease. Recruitment has begun for the trial, which will commence when 4,000 patients are enrolled. This form of diabetes disproportionately affects minorities, so 45 to 50 percent of patients recruited for the trial will be minorities -- with the exception of American Indians, who are addressed in a separate trial. The trial also has an explicit goal to involve minority staff and researchers. The trial is budgeted at \$25 million a year for about five years.

2. **National Diabetes Education Program (NDEP).** The NIDDK and the CDC in March 1998 will jointly launch the NDEP Public Awareness Campaign, which will focus heavily on minority

more specifics

DRAFT

populations. The annual budget for this activity will be \$1.5 to \$2.5 million.

3. Diabetes Control Programs. In FY 1998, the CDC will increase the number of state comprehensive diabetes programs by 7 to 9 states. Additional funding will allow the states to develop statewide, comprehensive diabetes program activities that target high-risk populations, including African-Americans, Hispanics, American Indians, Alaska Natives, Asians/Pacific Islanders, and the elderly.

→ timing
new
specific?

Goal 5: HIV/AIDS INFECTION RATES

LONG-TERM GOAL: Eliminate disparities in the rate of HIV/AIDS infection. *by 2010*

BACKGROUND: While racial and ethnic minorities account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities. During 1995-96, AIDS death rates declined 19 percent for the overall U.S. population, but only declined by 10 percent for Blacks and 16 percent for Hispanics.

Contributing factors to these disparities include late identification of the disease, the cost of effective treatment, lack of health insurance to pay for drug therapies, differences in access to HIV primary care, and inconsistent education and experience among physicians who treat underserved populations.

In September, the CDC funding 68 new community-based organizations for cooperative agreements for HIV prevention for minority and community-based organizations servicing populations at increased risk of acquiring or transmitting HIV infection.

NEAR-TERM GOALS: By the year 2000, assure early and equal access to health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS; establish educational outreach to all major medical providers to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children.

Is this realistic?

Is it going to

lead to more criticism from AIDS community that we

understand ADAP.

What about prevent goals

IMMEDIATE ACTION STEPS:

New
1. **HIV Community Planning**. The CDC in FY 1998 will invest \$14 million to strengthen health departments' capacity to provide prevention services, to those at highest risk, including racial and ethnic minorities. The CDC will strengthen and refine the HIV prevention community planning process to help develop priorities that specifically address unique community needs, including those of racial and ethnic populations.

2. **Communities of Color Initiative**. The CDC will develop an initiative by the end of FY 1998 that will focus on Black, Hispanic, American Indian, and Asian/Pacific Islander communities. These would involve identifying barriers to successful HIV prevention and solutions to those barriers. *need more specific of what this would do*

3. **HIV/AIDS CARE Grants to States (Ryan White Care Act Title II)**. Starting with this year's Title II application package, grantees will be required to provide information regarding the extent to which clients of their AIDS Drug Assistance Programs reflect the demographic characteristics of the HIV epidemic in their state. They must also discuss the state's plans to reach and enroll underserved populations in their Drug Assistance Program.

This is great. We can't do this as well as other states. For lots of programs.

DRAFT

Goal 6: CHILD AND ADULT IMMUNIZATIONS

LONG-TERM GOAL: Eliminate disparities in child and adult immunization rates.

BACKGROUND: Immunization is one of the most cost-effective ways to prevent needless illness and deaths, but minority and under served populations experience vaccine-preventable diseases at a rate that is out of proportion with the overall U.S. population. Among adults aged 65 or older in 1994, 57 percent of whites were immunized for influenza, compared with 39 percent of Blacks, 38 percent of Hispanics, and 43 percent of Asian/Pacific Islanders. For pneumococcal immunization, the rates were 30 percent for whites, 15 percent for Blacks, 14 percent for Hispanics, and 14 percent for Asian/Pacific Islanders.

Childhood immunization rates are at an all-time high, and immunization rates for minority and ethnic groups are closing the gap with those for white children. Even so, a gap still exists in some areas. The childhood vaccination rates in 1996 were 80 percent for white children, 76 percent for African Americans, and 73 percent for Hispanics. American Indian/Alaska Natives and Asian/Pacific Islanders achieved the highest childhood immunization rates of all at 81 percent.

NEAR-TERM GOALS: By the year 2000, double the 1994 influenza immunization rates among minority adults 65 and older and quadruple the 1994 pneumococcal immunization rates; achieve and maintain childhood immunization rates of 90 percent for all population groups.

IMMEDIATE ACTION STEPS:

A new
1. **HHS Action Plan.** *to target disparities* The Department of Health and Human Services will implement an agency-wide plan to improve adult immunization rates and reduce disparities among racial and ethnic communities -- particularly to increase flu and pneumococcal immunizations among all adults aged 65 and older

2. **Enhanced CDC Intervention Strategies.** The CDC is accelerating plans to enhance proven strategies to immunize pockets of under-immunized children. About \$100,000 will be used in FY 1998 to conduct immunization training courses to providers of immunization care services for minority children and to develop a distance-based immunization training program for health care professionals in major urban areas. —>

3. **Adult Flu and Pneumonia Vaccination Campaign.** This year, special efforts are being made to reach the medically underserved groups, through means such as the Historically Black Colleges and Universities, outreach to clergy, family physicians, pharmacies and home health agencies serving Black beneficiaries.

Anything should be doing? Medicare

PROPOSED HEALTHY LIFE GRANTS

Healthy Life

I. *Healthy Life* - Fact Sheet

II. Using the Healthy Start Model

III. Draft Departmental Funding Table

Healthy Life Grants -- Fact Sheet

OBJECTIVE OF PROGRAM: To demonstrate effective methods to reduce health disparities among minority populations in the areas of infant mortality, breast and cervical cancer, diabetes, heart disease and stroke, AIDS, and child and adult immunization rates in up to 30 communities.

- President's Racial and Ethnic Health Disparity Goal -- Eliminate minority health disparities by 2010.

NATURE OF THE PROGRAM: Local communities will compete for discretionary grants to address one of the six minority health disparities that it would like to reduce. Up to 30 grantees will be eligible to receive a total of \$15 million in "glue money" over a five year period to provide baseline assessment on the health problem in their area, develop an inventory of Federal, State, and local health care resources that addresses the problem, and develop and implement concrete action steps to ameliorate the health disparity.

COORDINATION WITH EXISTING PROGRAMS: To encourage increased collaboration and coordination among existing programs and related activities, HHS discretionary grant programs will give additional preferences and priorities to applicants that are participants in *Healthy Life* communities.

ELIGIBLE GRANTEES: Appropriate local public health and private non-profit agencies will be the eligible entities. Each grantee will be required to have a representative community board to review and endorse its action plan. Grant applications would require joint approval of the local chief executive and the Governor who are encouraged to have representation on the community board.

ANNUAL OPERATING PLANS: Each grantee will be required to submit an annual operating plan to HHS which will address the upcoming years actions and the progress made to date.

PROGRAM COST: The program will cost a total of \$450 million over 5 years -- FY 1999 through 2004 -- for 30 community projects. In addition, HHS will coordinate other program dollars that may flow into the *Healthy Life* grant areas.

→ need to include info into ~~the~~ that info gathered from these experiences will be used

to learn a lesson from successful strategies
to be adopted
Dept. to
reach by 2000
goals

SECRETARY'S COMMITMENT TO *Healthy Life*

I. SECRETARY'S FORUM – The Secretary will hold periodic conferences of *Healthy Life* Community Boards to report on their progress. These conferences will be forums to exchange data and lessons learned, as well as, to develop policy recommendations for the Secretary to further address minority health disparities.

II. HHS DATA/TECHNICAL ASSISTANCE TRAINING -- *Healthy Life* grantees receive technical and data collection assistance that will help them mount a high quality action plan to reduce health disparities in their local communities. The Secretary will:

- Ensure that grantees have access to needed expertise from within the Department and elsewhere.
- Provide access to education, training, and clinical skills improvement activities to the *Healthy Life* communities to develop innovative interdisciplinary approaches to solving their health disparity problems.
- Direct single points of contact or liaisons between *Healthy Life* grantees and Departmental experts to ensure that grantees have access to the latest research, data and information available.
- Designate Federal staff to be assigned to work directly with the *Healthy Life* grantees in the communities.

III. RESEARCH -- The Department will direct increasing attention to research promoting improvement in health status of minorities and expand participation of underrepresented minorities in all aspects of biomedical and behavioral research.

by who? validation!

USING THE HEALTHY START MODEL

There has been tremendous support for the "process" we used in developing the Healthy Start communities and their coalition building strategies to prevent and reduce infant mortality. We want to bring the lessons learned and the valuable experiences gained in designing these demonstration projects to support communities to develop sustainable solutions to the problems or minority health disparities.

We intend to create community driven systems, through seeking commitment and participation of community leaders, health care and social services providers, and other civic and religious organizations. We want to provide opportunities for community capacity building through coalitions to significantly reduce racial and ethnic health disparities.

We would entertain a wide variety of eligible governmental, private, and tribal entities as *Healthy Life* grantees who demonstrate a commitment and strategy for addressing a specific health disparity. We would also require the commitment and endorsement of State governments to ensure the success of the project.

We are also building on the experience of the Office of Minority Health's Minority Community Health Coalition Demonstration Grant Program. These were small one-year grants, renewable up to 3-years, with specific focuses on interventions-tobacco use cessation, hepatitis B, TB, etc.

Like Healthy Start and the Minority Community Health Coalitions, *Healthy Life* would maximize existing resources. Many programs remain categorically focused around immediate goals and reducing or preventing disparities among racial and ethnic minorities is not perceived as their charge. *Healthy Life* coalitions bring these programs to a shared table to invest in a vision which may exceed their individual goals. At the table, all stakeholders would begin to perceive a clear benefit in making efforts to utilize their existing resources--marshaling non-monetary strategies--to overcome turf issues, bureaucratic procedures and discrimination.

Healthy Start History:

- As of FY 1997, HRSA has a total of 60 Healthy Start grantees and has spent a cumulative total of \$556 million. The demonstration program began in FY 1991 with 15 communities which had exceptionally high infant mortality rates receiving a total of \$25 million in planning funds. The program was expanded in FY 1994 to seven additional communities. In FY 1997, HHS has begun the replication phase of the Healthy Start program and awarded 40 new grants to implement successful infant mortality reduction strategies developed by the original grantees.
- Some of our successes have been:
 - In Pittsburgh, decreases in low birthweight births 6.5% compared to 12.8%.
 - In Philadelphia, project experienced 30.8% reduction using alcohol during pregnancy.

- In Washington, DC, births to adolescents declined 11%; in Philadelphia 14%.
- New York reported a 40% reduction in infant mortality in the project catchment area, resulting in a 24% citywide decline.
- In Baltimore, case management techniques reduced substance abuse, inappropriate weight gain, and under utilization of prenatal care, resulting in lower rates of low birthweight births, poor pregnancy outcomes, and reductions in infant mortality.

DRAFT

FY 1999 President's Initiative on Race
Department of Health and Human Services
 (\$ in thousands)

Don't understand this need for PLS - (Ken)

Budget Activity by OPDIV	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6
	Infant Mortality	Breast & Cervical Cancer	Heart Disease & Stroke	Diabetes	AIDS	Immunization
FDA						
HRSA						
Health Centers	312,701					
NHSC Recruitment Program	28,347					
NHSC Field	13,884					
Nurse Practitioner/Midwife	5,638					
MCH Block Grant	241,706					
Healthy Start	170,982					
Rural Health Outreach grants	11,361					
Ryan White:						
Early Intervention - Part C	34,351					
Pediatric HIV/AIDS - Part D	40,000					
Family Planning	218,452					
Tobacco/Substance Abuse			1,000			
Lower Extremity Amputation Prevention				100		
Emergency Relief - Part A					466,886	
Comprehensive Care - Part B					578,854	
Early Intervention - Part C					99,568	
Pediatric HIV/AIDS - Part D					40,000	
Education and Training Centers - Part F II (a)					17,287	
Dental Services - Part F II (b)					7,500	
Childhood and Other Immunization						1,600
IHS						
Model Diabetes Program (24 Tribal Sites)				8,151		
Diabetes Treatment & Prevention Grants				30,000		
Viral Hepatitis and H. Influenza Type B (Hib) Immunization Program in Alaska						1,369
CDC/1						
HIV/AIDS	28,876				66,000	
Sexually Transmitted Diseases	16,565					
Immunization						342,145
Heart Disease & Health Promotion			30,700			
Diabetes & Other Chronic Disease				8,600		
Environmental Disease Prevention	15,948					
Breast & Cervical Cancer Prevention		70,000				
Infectious Diseases	7,607					
Epidemic Services	6,806					
Health Statistics	7,052					
NIH	127,000	41,000	216,000	125,000	311,000	64,000
SAMHSA						
Knowledge Development and Application					20,300	
Targeted Capacity Expansion					1,000	
Substance Abuse Block Grant					55,122	
Program Management					580	
ACHPR						
Crosscut	4,500	2,600	2,450	2,500	2,300	
Specific to Goal	3,970	0	500	733	2,300	
HCFA						
Medicare 11					2,000,000	75,000
Medicaid					1,500,000	200,000
TOTALS BY GOALS	\$1,295,846	\$113,600	\$250,650	\$175,084	\$5,168,597	\$684,114

Alternatively, Medicare and Medicaid data may be presented as total estimated spending for "Minority Health & Assistance" which presents a Medicaid figure of \$37,081,980 and \$29,484,000 for Medicare in FY 1999. This figure is not broken out by Goals.
 /1 The Multi-city Mammography project and the Good Neighbor program are subsets of Medicaid.
 Data reported for Medicare and Medicaid are preliminary and will be updated as they become available.

**FY 1998 President's Initiative on Race
Department of Health and Human Services
(\$ in thousands)**

Budget Activity by OPDIV	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6
	<i>Infant Mortality</i>	<i>Breast & Cervical Cancer</i>	<i>Heart Disease & Stroke</i>	<i>Diabetes</i>	<i>AIDS</i>	<i>Immunization</i>
FDA						
HRSA						
Health Centers	283,877					
NHSC Recruitment Program	28,551					
NHSC Field	12,849					
Nurse Education/Practice	4,461					
Nurse Practitioner/Midwife	5,776					
MCH Block Grant	223,649					
Healthy Start	95,982					
Rural Health Outreach grants	12,170					
Ryan White:						
Early Intervention - Part C	27,451					
Pediatric HIV/AIDS - Part D	45,000					
Family Planning	208,452					
Lower Extremity Amputation Prevention				100		
Emergency Relief - Part A					471,663	
Comprehensive Care - Part B					560,994	
Early Intervention - Part C					79,568	
Pediatric HIV/AIDS - Part D					45,000	
Education and Training Centers - Part F II (a)					17,287	
Dental Services - Part F II (b)					7,860	
Childhood and Other Immunization						1,600
HHS						
Model Diabetes Program (24 Tribal Sites)				7,882		
Diabetes Treatment & Prevention Grants				30,000		
Viral Hepatitis and H. Influenza Type b in AK						1,328
CDC / 2						
HIV/AIDS	26,069				65,500	
Sexually Transmitted Diseases	18,585					
Immunization						326,580
Heart Disease & Health Promotion			14,252			
Diabetes & Other Chronic Disease				7,489		
Environmental Disease Prevention	15,150					
Breast & Cervical Cancer Prevention		71,000				
Infectious Diseases	5,001					
Epidemic Services	6,806					
Health Statistics	6,677					
NIH						
	120,000	39,000	205,000	120,000	297,000	60,000
SAMHSA						
Knowledge Development and Application					13,904	
Substance Abuse Block Grant					52,920	
Program Management					580	
ACHPR						
Crosscut	3,100	1,800	1,700	1,500	500	0
Specific to Goal	2,181	0	0	233	0	0
HCFA						
Medicare /1				5,900,000	1,400,000	180,000
Medicaid					1,900,000	70,000
TOTALS BY GOALS	\$1,149,567	\$111,600	\$220,952	\$6,067,204	\$4,912,776	\$639,508

/1 The Multi-city Mammography project and the Good Neighbor program are subsets of Medicare.
Data reported for Medicare and Medicaid are preliminary and will be updated as they become available.



ONE AMERICA IN THE 21ST CENTURY

The President's Initiative on Race

The New Executive Office Building
Washington, DC 20503
202/395-1010

File
Race + Health

To: Jose Cerda
From: Michele Cavataio
Date: September 17, 1997
Subject: Data collection

Attached are the cover memos we received from the relevant agencies on data related to race. Some of these memos do not contain actually data because the data came in big boxes which are sitting on the floor of my office. I am having someone sort through it this week, and we may eventually have a summary. Let me know if you need anything else.

Stol Melissa
Dr. 301 - Skolfield
P6/b(6) → breast
CENTER cancer.
for Joe
Deuces Le
regulatory 443,
4690